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Supreme Court, U.S.
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No. 95-1118

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Petitioners,

v.

MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the court of appeals erred when it concluded that a jury's finding of an "HMO" product market was not reasonably supported by the evidence.

2. Whether the court of appeals erred when it concluded that a jury's finding that an HMO provider contract constituted price-fixing was not reasonably supported by the evidence.

PARTIES TO THE PROCEEDINGS

All parties in the courts below and here are listed in the caption. Respondent Marshfield Clinic is the corporate parent of respondent Security Health Plan of Wisconsin, Inc. Neither Marshfield nor Security has any partly owned subsidiaries.

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RESPONDENTS' BRIEF IN OPPOSITION

INTRODUCTION

Neither repeated mischaracterization of the decision below nor the plain fabrication of "record" facts can mask the true nature of this petition: it seeks interlocutory review of nothing more than the sufficiency of evidence to support two "jury findings" (Pet. i) on essential elements of petitioners' antitrust claims. The petition thus raises no legal question at all: only whether the court of appeals erred in its application of record facts to settled (and here unchallenged) principles of law. Unable to cite a contrary holding of this Court or any other Circuit, petitioners must resort to criticizing the court of appeals

for secretly relying on "preconceived economic theories." Pet. 13. Yet it is they who invoke "[r]ecent scholarship" (Pet. 22) to launch an extended attack on the academic writings of Chief Judge Posner, the author of the unanimous opinion below. Petitioners' attack, however, ignores the decision itself, which by its terms is factbound; in fact, the decision expressly declares as to both questions presented here that another plaintiff on a different record might well succeed.

The petition also fails to disclose the alternative rulings that independently support the judgment below and would require affirmance no matter how the questions presented were decided. Thus, even if an "HMO" market had been proven, the circuit court's unchallenged conclusion that the *quality* of the Marshfield Clinic's physicians could not render it an "essential facility" would dispose of petitioner Compcare's claim for exclusion from the market. Even if the affiliation agreements between Marshfield's HMO and independent doctors were subject to attack for the use of "most favored nations" clauses, the circuit court's unchallenged rejection of the findings related to market definition and market power would dispose of petitioner Blue Cross's claim that the agreements unreasonably restrained trade.

Finally, the record on which petitioners base their request for review is so fundamentally deficient as to render this case a dismally inappropriate vehicle for thorough analysis of either question presented. In attempting to define an "HMO" market separate from other health insurance products, petitioners (1) were flatly contradicted by the testimony of their own expert economist, (2) repeatedly conceded that HMOs and other health plans "compete" for "the same prospects" (Tr. 631), and (3) failed to address the issue of supply substitution entirely.

Even worse, petitioners' argument on "most favored nations" clauses is based on a disturbing misrepresentation of the record. Seizing upon dicta in Chief Judge

Posner's opinion, petitioners contend for the first time in this Court that Marshfield's HMO provider contracts contain an actual " 'most favored nation' ('MFN') *clause.*" Pet. 4 (emphasis added). Not once during trial or on appeal did petitioners ever refer to MFN clauses, much less claim that the provider contracts contained them. As shown below, petitioners know that no such clause exists.

In sum, this record will support neither plaintiffs' position on the merits, nor the informed exploration of any issue related to HMO markets or MFNs.

STATEMENT

1. Respondent Marshfield Clinic, a medical clinic based in the city of Marshfield, Wisconsin, provides physician services to patients on a fee-for-service basis. Pet. App. 2a-3a. Marshfield employs about 400 primary care physicians and specialists at various clinics throughout mostly rural areas in northern and central Wisconsin. *Id.* Marshfield is, according to petitioners, "one of the most prominent medical clinics in the country." Tr. Ex. 304.

Respondent Security Health Plan of Wisconsin, Inc. ("Security"), a health maintenance organization ("HMO") owned and operated by Marshfield, provides pre-paid physician services at fixed monthly rates. To provide those services, Security contracts with Marshfield and with approximately 900 independent physicians known as "affiliates." Pet. App. 3a. The affiliated provider contracts are non-exclusive; affiliates may treat non-Security patients either on a fee-for-service basis, in competition with Marshfield, or through alternative HMO networks, in competition with Security. *Id.* Affiliates derive only a small percentage of their total income from treatment provided to Security patients. *Id.*[1]

[1] In addition to the evidence relied on by the court of appeals for this proposition (Pet. App. 65a), other unchallenged testimony confirms that affiliates derived only a small portion of their income

Petitioner Blue Cross & Blue Shield United of Wisconsin, an insurance company, sells indemnity health insurance to customers, many of whom purchase physician services from Marshfield. Pet. App. 13a-14a. Petitioner Compcare Health Services Insurance Corporation, a Blue Cross subsidiary, is an HMO that directly competes against Security. Pet. App. 2a.

2. On February 16, 1994, petitioners filed this antitrust action against respondents in the United States District Court for the Western District of Wisconsin. To prove their respective claims for monopolization, petitioners sought to define no fewer than 520 assertedly distinct physician services markets: 13 primary care markets, 13 pediatric care markets, and 494 specialty care markets. Pet. App. 8a-9a, 29a-30a, 61a. Petitioners urged at trial that Marshfield possessed monopoly or market power in "one or more" of each kind of market. Pet. App. 74a-75a.

Compare's monopolization claim was based on the "essential facilities" doctrine (Pet. App. 27a), which under limited circumstances may require a monopolist in an upstream market to sell goods or services "essential" to competition in a downstream market, *see, e.g., MCI Communications Co. v. AT&T*, 708 F.2d 1081, 1133 (7th Cir.), *cert. denied*, 464 U.S. 891 (1983). Specifically, Compcare alleged that because Marshfield's physicians were the "best" in the area (Pet. App. 12a), it had an affirmative duty to sell physician services to Compcare, in order to assist Compcare in its competition against Security. Pet. App. 27a-28a.[2] As a result of Marshfield's

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from treating Security patients. Tr. 905 ("no more than five to eight percent"); Tr. 1735 ("5 percent or less"); Tr. 1773 ("[a]pproximately four percent").

[2] Although Compcare initially denied to the court of appeals that its essential facilities claim was based on the high quality of Marshfield, the record makes clear that it was. *E.g.*, Tr. 328 ("customers feel [Marshfield's] quality is best and they feel the service is best");

failure to do so—at least on terms demanded by petitioners—Compcare alleged that it had suffered an antitrust injury defined as "exclusion" from a putative "HMO services" market. Pet. App. 2a, 23a, 45a.

Blue Cross took a more blunderbuss approach, raising claims of monopolization, conspiracy and every other theory known to the Sherman Act, based upon virtually every major business decision made by Marshfield over the course of two decades. These included every one of its acquisitions of any clinic or physician practice and all of its employment contracts; these included the very existence of the HMO and the hundreds of affiliated provider contracts it entered into; these also included a variety of service contracts and joint ventures with at least six uncharged parties not involved in this litigation. Pet. App. 33a, 45a-53a. Blue Cross specifically challenged the affiliated provider contracts, by which Security contracted with physicians not employed by Marshfield, as "price-fixing." Pet. App. 36a. Blue Cross alleged that Marshfield, as a result of this various conduct, was able to charge "supracompetitive prices" to patients and thus increase Blue Cross's cost of performing under its indemnity contracts with those patients. Pet. App. 2a, 28a.

Tr. 616 ("From a consumer's standpoint it would be a better network if we had Marshfield Clinic."); Tr. 978 ("the best doctors in Central Wisconsin"); Tr. 1115 ("if quality is what the employer is looking for, you have to have that clinic"); Tr. 2403 (petitioners' final argument) ("Even if [other doctors] signed up with us, we couldn't get any business because we can't get the Marshfield Clinic. So it wouldn't make any difference.").

Petitioners subsequently conceded that this claim was based on quality: "This Court's determination, that the reputation for quality of defendants' physicians may not make them an essential facility (for the entry of a competing HMO), is both [sic] contrary to its own decision[s] . . ., and it conflicts with . . . *Eastman Kodak* . . . ." Appellees' Motion to Stay Mandate Pending Petition for Writ of Certiorari at 6-7 (Oct. 18, 1995).

The jury found for petitioners on all counts. Pet. App. 74a-75a. The jury awarded damages, before trebling, of $10.5 million to Blue Cross (Pet. App. 39a) and $5,669,277 to Compcare. Pet. App. 42a.

3. On post-trial motions, the district court upheld the jury's liability determinations in virtually all relevant respects. The court found (a) sufficient evidence to support, among other things, jury findings that Marshfield has monopoly power in "one or more" physician services markets for primary care, pediatric care, and specialty care (Pet. App. 29a-32a); (b) sufficient evidence of an "HMO services" market and an essential facilities violation (Pet. App. 23a-28a);[3] (c) sufficient evidence to conclude that the affiliated provider contracts constituted "price fixing" (Pet. App. 36a); and (d) sufficient evidence to conclude that Marshfield had engaged in several illegal conspiracies (Pet. App. 36a-37a, 47a-53a).[4]

Through a remittitur, the district court reduced by 65% the jury's damages awards, which it characterized as "monstrously excessive." Pet. App. 39a, 43a. The court reduced Blue Cross's untrebled award, which the jury had determined "[m]agically" (Pet. App. 38a), from $10.5 million to $594,833. Pet. App. 42a.[5] The court also re-

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[3] The district court recognized that Compcare could not prevail on any claim "[w]ithout an HMO market" and held further that Compcare had waived its "late attempts" to argue alternative theories. Pet. App. 23a. Compcare did not challenge either of these rulings on appeal.

[4] The court acknowledged that an "inconsistency" in its special verdict form foreclosed liability for attempted monopolization. Pet. App. 33a-34a. The court held, however, that the failure of that claim in no way restricted the remedies available to petitioners. Pet. App. 34a.

[5] During the damages trial, petitioners presented testimony that Blue Cross had suffered "overcharge" damages of approximately $594,000. Pet. App. 39a. The $10.5 million was a figure advocated only in closing argument by petitioners' counsel, who urged the jury to disregard the testimony of his own expert. Pet. App. 38a; Tr. 2834-35.

duced Compcare's untrebled award to $5,074,394, in order to offset the jury's multiple computational errors. Pet. App. 39a, 43a, 63a.

Finally, the district court granted petitioners a "sweeping" injunction (Pet. App. 2a) that, among other things, required Marshfield to sell physician services to Compcare on a "nondiscriminatory" basis (Pet. App. 58a), prohibited respondents from charging any "supra-competitive" prices (*id.*), and voided entire categories of respondents' business contracts (Pet. App. 55a-57a). The court of appeals stayed the injunction pending appeal. Pet. App. 2a.

4. The court of appeals unanimously affirmed in part, reversed in part, and remanded for further proceedings. In so doing, the court addressed only two questions that were purely legal: whether Blue Cross, as an indemnity insurer of Marshfield patients, has standing to sue Marshfield for alleged overcharges (Pet. App. 14a-15a); and whether the "superb" quality of Marshfield physician services could render them "essential" for purposes of the essential facilities doctrine (Pet. App. 12a). Every other issue resolved by the court of appeals, as petitioners now explain, involved challenges to the "sufficiency of the evidence." Pet. 7.

At the outset, the court held that Compcare had produced insufficient evidence to support the finding of a separate market for "HMO services." The court began by correctly stating its limited standard of review: "if there is a reasonable basis for this finding in the evidence, we are bound to accept it regardless of what we think as an original matter." Pet. App. 3a. The court also correctly stated the applicable legal rule: "[i]n defining a market, one must consider substitution by buyers and by sellers." Pet. App. 5a (citing IIA P. Areeda, J. Solow & H. Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 530a (1995)). The court "searched the record in vain for evidence" of an "HMO

services" market. Pet. App. 3a. Having done so, it concluded: "We thus do not believe that a reasonable jury, confronted with the record compiled in the district court, could find that HMOs constitute a separate market." Pet. App. 7a.

The court also held that, in all events, Marshfield had no affirmative obligation to deal with Compcare, because the high quality of Marshfield physician services (Pet. App. 12a) could not make those services "essential" for purposes of the essential facilities doctrine: "The suggestion that the price of being 'best' is to be brought under the regulatory aegis of antitrust law and stripped of your power to decide whom to do business with does not identify an interest that the antitrust laws protect." *Id.* That holding, dispositive of all of petitioner Compcare's claims, has not been challenged in this Court.

The court also addressed various issues involving market definition and power in the physician services markets alleged by petitioners. The court held that petitioners had produced insufficient evidence to prove any well-defined primary care markets (Pet. App. 7a-8a), pediatric care markets (*id.*), or specialty care markets (Pet. App. 8a). Even assuming proper markets, the court also held that petitioners had produced insufficient evidence that Marshfield has power in any physician services market. Pet. App. 7a-8a, 10a. Marshfield Clinic, the court concluded, "is not a monopolist." Pet. App. 10a. These holdings, dispositive of all of petitioners' claims (other than those based on *per se* theories of liability), have not been challenged in this Court.

The court also held that Blue Cross had produced insufficient evidence to support the jury's finding that Security's affiliated provider contracts constitute price fixing. Pet. App. 16a-17a. Petitioners had argued to the court of appeals that those agreements constitute "price fixing" because their "practical result" is "to establish a floor

for *all* of an affiliate's charges, *not* just charges to Marshfield." Appellees' Brief and Supplemental Appendix at 15 (July 20, 1995) ("Appellees' Br.").[6] Noting that the agreements themselves constituted "the only evidence of collusion" with the affiliates, and construing petitioners' argument to be that the agreements contained express MFN clauses, the court observed that such clauses are "not price-fixing." Pet. App. 17a.

> 'Most favored nations' clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers. The Clinic did this to minimize the cost of these physicians to it, and that is the sort of conduct that the anti-trust laws seek to encourage. It is not price-fixing. [*Id.*]

Addressing the numerous contracts attacked by Blue Cross under a *per se* theory of market division, the court found "sufficient" (though "scanty") evidence of a single illegal agreement between Marshfield and the North Central Health Protection Plan, an uncharged third party, "not to open offices in each other's territories." Pet. App. 17a-18a. The court remanded the case to the district court for a determination of the Clayton Act damages, if any,

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[6] Petitioners addressed the affiliated provider contracts only in a section of their brief titled "Price Fixing," which argued as follows:

> The "Affiliated Provider Subcontract" . . . is not, as Marshfield states, a "buyer and seller setting a price." Affiliated physicians must submit to Marshfield a schedule of their "usual and customary charges" and their Marshfield payment is based on that schedule. Obviously, Marshfield does not wish to pay the affiliates more than the affiliates charge their non-enrollee patients, and *the practical result of the contracts* is to establish a floor for *all* of an affiliate's charges, *not* just charges to Marshfield. Thus, the physician's fee schedule subject to Marshfield's approval is the only one in effect for all of the physician's patients.

Appellees' Br. at 15 (first emphasis added) (citations omitted).

flowing to Blue Cross from that one agreement. Pet. App. 19a.

Finally, the court approved an injunction limited to the prohibition of market division agreements in the future. *Id.* The court vacated the entire injunction imposed by the district court, however, and it ordered any injunction on remand "to be rewritten from scratch." *Id.*

5. On rehearing in the court of appeals, the United States and the Federal Trade Commission filed a brief *amici curiae* that took "no position on the sufficiency of the record to support the jury's verdict," but expressed "concer[n]" that the court's opinion "may mislead readers unfamiliar with the record and arguments in this case." Pet. App. 68a. The government asserted that "the Court's statement that 'HMOs are not a market' . . . might be read *inappropriately* out of context, to establish a rule of general applicability." Pet. App. 69a (emphasis added). The government also expressed concern that the opinion "may be *misinterpreted* as a holding that [MFN] clauses never violate the Sherman Act," although it expressly agreed that "MFN clauses may serve legitimate purposes in particular circumstances," and did "*not* dispute the Court's conclusion that the record in this case does not establish per se illegal price fixing." Pet. App. 71a (emphases added). The government urged the panel to "modify its opinion" to "leave no doubt" on these issues. Pet. App. 73a.

Although the court had expressly tied its holding to the record in several places, it nonetheless obliged. After its statement that no "reasonable jury, confronted with the record compiled in the district court, could find that HMOs constitute a separate market" (Pet. App. 7a), the court added another sentence repeating itself: "We emphasize 'record compiled in the district court.'" Pet. App. 65a. With regard to its statement that MFN clauses are "not price-fixing" (Pet. App. 17a), the court added a sentence

explaining: "Perhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case." Pet. App. 65a.

REASONS FOR DENYING THE WRIT

The petition for certiorari is insubstantial if not frivolous. On its face, the petition raises no legal question for this Court's review, but simply challenges two sufficiency determinations that the court of appeals explicitly limited to the record in this case. Moreover, the petition fails to challenge several additional holdings that independently support all portions of the judgment challenged here by petitioners. Finally, even assuming that petitioners' sufficiency claims would otherwise warrant review, they are meritless in any event.

I. PETITIONERS RAISE NO LEGAL QUESTION FOR THIS COURT'S REVIEW

The questions presented, stripped of their lengthy and conclusory summations of purported evidence, seek review of whether the court of appeals incorrectly overturned jury factfinding. Question 1 asks this Court to determine whether the court of appeals "correctly overturned a jury finding" that "HMO services" constitute a separate product market. Pet. i. Similarly, Question 2 seeks review of whether, in light of the supposed MFN clauses, the court of appeals "correctly overturned jury findings" of monopolization and conspiracy. *Id.* This Court, however, "do[es] not grant a certiorari to review evidence and discuss specific facts." *United States v. Johnston*, 268 U.S. 220, 227 (1925). *See, e.g., NLRB v. Hendricks County Rural Electric Membership Corp.*, 454 U.S. 170, 176 n.8 (1981); R. Stern, E. Gressman, S. Shapiro, K. Geller, *Supreme Court Practice* § 4.14, at 189-90 (7th ed. 1993).

The body of the petition fares no better. With regard to the alleged "HMO services" market, petitioners do not

seriously take issue with the court of appeals' statement that market definition ultimately turns on "substitution both by buyers and sellers" (Pet. App. 5a). As this Court has long held, a proper antitrust market " 'is composed of products that have reasonable interchangeability.' " *Eastman Kodak Co. v. Image Technical Serv. Inc.*, 504 U.S. 451, 481 (1992) (quoting *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 404 (1956)). In a single footnote, petitioners briefly suggest that the "practical indicia" set forth in *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962), supply a different legal standard. Pet. 14 n.10. *Brown Shoe* itself, however, made clear that the relevant market "must be drawn with sufficient breadth to include the competing products." 370 U.S. at 326. Thus, the courts of appeals have recognized that *Brown Shoe*'s "practical indicia" are merely "evidentiary proxies for direct proof of substitutability." *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.*, 792 F.2d 210, 218 (D.C. Cir. 1986), *cert. denied*, 479 U.S. 1033 (1987).[7] Petitioners' own authority makes this clear. *See, e.g., U.S. Anchor Mfg., Inc. v. Rule Indus., Inc.*, 7 F.3d 986, 995 (11th Cir. 1993) ("practical indicia" are "equivalent" to substitutability), *cert. denied*, 114 S. Ct. 2710 (1994); *H.J., Inc. v. ITT Corp.*, 867 F.2d 1531, 1540 (8th Cir. 1989) (quoting *Rothery*).

Petitioners also fail to identify any legal controversy (much less a circuit split) regarding the application of these principles in the specific context of alleged markets for "HMO services." On the contrary, petitioners concede that the definition of particular markets "is an intensely fact-based undertaking." Pet. 13. Moreover, petitioners do not cite even a single case where a plaintiff has successfully proven an "HMO services" market, and

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[7] *Accord, e.g., White & White, Inc. v. American Hosp. Supply Corp.*, 723 F.2d 495, 502 (6th Cir. 1983); *Thurman Indus. Inc. v. Pay 'N Pak Stores, Inc.*, 875 F.2d 1369, 1375-77 (9th Cir. 1989); II P. Areeda & D. Turner, *Antitrust Law* ¶ 535b, at 419-21 (1978).

they ignore several decisions finding legally insufficient proof of an "HMO services" market narrow enough to exclude all alternative forms of health insurance. *See Hassan v. Independent Practice Assocs., P.C.*, 698 F. Supp. 679, 695 n.47 (E.D. Mich. 1988) (granting summary judgment); *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 692 F. Supp. 52, 68 (D.R.I. 1988) (granting JNOV), *aff'd*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); *National Benefit Administrators v. Blue Cross & Blue Shield of Alabama*, 1989-2 Trade Cas. (CCH) ¶ 68,831, 62,372 (M.D. Ala. 1989) (granting summary judgment), *aff'd without op.*, 906 F.2d 1143 (11th Cir. 1990).[8]

Petitioners also raise no legal question regarding the alleged MFN clause in the affiliated provider contracts. Petitioners do not, and could not, seek to extend to MFN classes the *per se* rule—which is limited to discrete categories of agreements that are " 'always or almost always' " anticompetitive, *Northwest Wholesale Stationers v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 289-90 (1985) (citation omitted). As the government noted in the court of appeals, "MFN clauses may serve legitimate purposes in particular circumstances." Pet. App. 71a.[9] Indeed, petitioners made a similar argument to the district court

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[8] In the only HMO decision cited by petitioners (Pet. 14), a magistrate judge rejected an alleged "HMO services" market as a factual matter, and the First Circuit affirmed. *See U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 598-99 (1st Cir. 1993). *See also Ball Memorial Hosp. v. Mutual Hosp. Ins. Inc.*, 784 F.2d 1325, 1331 (7th Cir. 1986) (also affirming rejection of alleged "HMO services" market).

[9] *See also Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1110 (1st Cir. 1989) (MFN clause "tends to further competition on the merits"), *cert. denied*, 494 U.S. 1027 (1990); *Associated Milk Dealers, Inc. v. Milk Drivers Union, Local 753*, 422 F.2d 546, 554 (7th Cir. 1970) (MFN clause not subject to *per se* rule).

when they sought to include in the injunctive order an MFN clause in favor of *themselves*. MFN clauses, they argued, "have been enthusiastically approved by courts that have addressed them since such clauses *increase* price competition." Plaintiffs' Reply Brief in Support of Motion for Entry of an Order for Declaratory and Injunctive Relief at 102 (Feb. 21, 1995) (emphasis in original). Nor do petitioners identify any legal question regarding either the rule of reason or its application in the specific context of MFN clauses.

Instead, petitioners attempt to mischaracterize the grounds of the court of appeals' decision. Petitioners contend that the decision rests on "economic generalizations rather than record evidence" (Pet. 10); that "nothing in the court's analysis" is "limited to a particular time, place, or trial record" (*id.*); that the court "generally endorsed MFN clauses" (Pet. 20); and that other courts, in future cases, will have no "basis for distinguishing" the court's holdings (Pet. 12). Petitioners seek to buttress these characterizations with extended criticism (Pet. 18-23) of the academic writings of Chief Judge Posner and Judge Easterbrook (who was not on the panel below), and with the astonishing suggestion that because Chief Judge Posner has displayed "facility with economic analysis" (Pet. 8) his decision for a unanimous panel must reflect "dogmatic generalizations based on preconceived economic theories" (Pet. 13).

Petitioners' charges are meritless. Petitioners ignore the fact that the appeal below, in their own words, raised only "sufficiency of the evidence" challenges. Pet. 7. More importantly, petitioners ignore what the court of appeals actually said. With respect to the alleged "HMO services" market, the court noted that "if there is a reasonable basis for this finding in the evidence, we are bound to accept it." Pet. App. 3a. After concluding that no "reasonable jury, confronted with the record compiled in the district court, could find that HMOs constitute a sep-

arate market" (Pet. App. 7a), the court granted the government's request that it "leave no doubt" (Pet. App. 73a): "We emphasize 'record compiled in the district court.'" Pet. App. 65a. Similarly, with respect to the alleged MFN clause, the court stated explicitly that such clauses might be "misused to anticompetitive ends" in other cases, but that "there is no evidence of that in this case." *Id.*

Ultimately, petitioners are left to complain that the decision below, limited by its terms to the trial record, is not larded with "citation" to specific pages in "the trial record." Pet. 11. Leaving to one side the pointlessness of citing the record for a *lack* of evidence, this Court's job "'is to review judgments, not to edit opinions.'" *Powell v. Nevada*, 114 S. Ct. 1280, 1285 (1994) (Thomas J., dissenting) (quoting *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 823 (1985) (Stevens, J., concurring in part and dissenting in part)).[10]

Because petitioners raise only sufficiency challenges, and have identified no legal issue for this Court's review, the Court should deny their petition.

II. PETITIONERS FAIL TO CHALLENGE ALTERNATIVE HOLDINGS THAT INDEPENDENTLY SUPPORT THE DECISION BELOW

Even assuming that petitioners' two sufficiency claims would otherwise warrant review, petitioners fail to chal-

[10] Equally insubstantial is petitioners' argument (Pet. 28-29) that *amicus* participation and media coverage of this case below somehow establish the importance of the sufficiency questions raised in their petition to this Court. Only one *amicus* supported petitioners, addressing only a single question: the standing of a purchaser's indemnity insurer to raise antitrust claims against the seller. The media coverage, moreover, was a result of "the prominence of the featured players and the dollar value of the jury verdicts," B. Clay & M. LaFond, *Antitrust and Integrated Delivery Systems*, Health L. Dig., Feb. 1995, at 9, not the sufficiency issues in a particular antitrust case.

lenge several additional holdings by the court of appeals that independently support its judgment.

Most significantly, petitioners do not challenge the court of appeals' critical holdings with respect to market definition and power in the various alleged physician services markets. First, the court of appeals found petitioners' "dizzying series of concentric circles" insufficient to establish plausible geographic markets for primary and pediatric care. Pet. App. 8a.[11] Second, the court of appeals held that petitioners did not establish separate specialty care markets corresponding to each of 494 diagnostic related groups. Pet. App. 8a.[12] Third, the court of appeals held that petitioners in all events did not establish monopoly or market power in any physician services market. Pet. App. 7a-8a, 9a.[13] Petitioners do not, and could not, challenge any of these rulings.

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[11] At trial, petitioners' economist drew circles of approximately 30 to 50 miles around 13 Marshfield offices. Pet. App. 61a. He testified that *each circle* constituted a separate primary care and pediatric care market (Pet. App. 23a)—even though some circles are entirely contained within others and even though some areas are encompassed within no fewer than six different circles.

[12] As the court of appeals explained, DRGs, which were developed as a system for classifying the expected cost of hospital charges, *see, e.g., West Virginia Univ. Hosp. v. Casey*, 885 F.2d 11, 15-16 (3d Cir. 1989), *aff'd*, 499 U.S. 83 (1991), are "unrelated to the conditions of supply." Pet. App. 8a. Petitioners' unprecedented use of DRGs to define specialty care markets would have produced absurd consequences such as distinct antitrust markets for "circumcision of a male 17 years or older" and "circumcision of a male under 17." *Id.*

[13] To allege shares that could support an inference of market power, petitioners were forced to attribute to Marshfield *all* treatment rendered by the 900 Security affiliates (Pet. App. 3a, 31a-32a), even though the affiliates derive only a small fraction of their total income from their non-exclusive contracts with Security (Pet. App. 3a, 7a, 65a). Petitioners also were forced to assert, as they continue to do, that Marshfield prices "exceed statewide averages by 30%." Pet. 3 n.3. But as the court of appeals explained, higher than average prices cannot support an inference

The absence of any physician services markets in which Marshfield has power, which is now the law of this case, independently forecloses all claims that petitioners seek to raise here. First, to establish liability based on Marshfield's unilateral refusal to sell physician services to Compcare—under the essential facilities doctrine or otherwise —Compcare must show, at a minimum, that Marshfield has monopoly power in well-defined physician services markets. *See, e.g., Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 600-03 (1985); *MCI Communications Co. v. AT&T*, 708 F.2d 1081, 1133 (7th Cir.), *cert. denied*, 464 U.S. 891 (1983). Regardless of what this Court might say about the alleged "HMO services" market, Compcare's claim is foreclosed by the court of appeals' unchallenged holding that Marshfield "is not a monopolist" in any physician services market. Pet. App. 10a.

Second, the court's holdings as to physician services markets also foreclose Blue Cross's conspiracy claim based on the alleged MFN clauses. As noted above, Blue Cross challenges the use of an alleged MFN clause only under the Rule of Reason—which requires a showing of markets, power, and specific anticompetitive impacts. *See, e.g., Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 45 (1977); *Illinois Corp. Travel, Inc. v. American Airlines, Inc.*, 806 F.2d 722, 727 (7th Cir. 1986). Regardless of what this Court might say about MFN clauses generally, Blue Cross cannot establish that Marshfield committed any rule of reason violation here, where the court of appeals' holdings as to physician services markets remain unchallenged.

Finally, Compcare's essential facilities claim fails on yet another independent and unchallenged holding below:

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of market power here, where petitioners not only concede Marshfield's "superb" quality (Pet. App. 12a), but use that quality as the basis for Compcare's essential facilities claim. Pet. App. 9a ("Generally you must pay more for higher quality.").

that regardless of any question about market power, Marshfield Clinic's "reputation for high quality" could not render Marshfield physician services "essential" for purposes of the essential facilities doctrine, because "the price of being 'best' is [not] to be . . . stripped of your power to decide whom to do business with . . . ." Pet. App. 12a.

This Court should reject petitioners' invitation not only to make sufficiency determinations, but to do so on issues that cannot possibly affect the ultimate outcome of the case.

III. PETITIONERS' SUFFICIENCY CLAIMS LACK MERIT

Beyond their other fatal difficulties, petitioners' sufficiency claims are also meritless. Indeed, the record is so deficient on these issues that it would frustrate any attempt at thorough consideration by this Court of any question presented.

A. Petitioners Failed To Prove An "HMO Services" Market

The record below makes clear that HMO products are reasonably interchangeable with, and face substantial competition from, other forms of health insurance or health care financing products, including preferred provider organizations ("PPOs") and traditional indemnity products such as those sold by Blue Cross.

Petitioners' own documents proved the point. A Blue Cross securities filing states that Compcare "face[s] substantial competition from other HMOs, PPOs, self-funded plans, the Parent [*i.e.*, Blue Cross] and indemnity insurance carriers." Tr. Ex. 236 at 18. A Blue Cross research memorandum notes that PPOs are "prime competition for HMOs." Tr. Ex. 335 at 5. And a Blue Cross marketing plan lists "competition" as including indemnity, HMO, PPO, and other plans. Tr. Ex. 337 at

025571-73. Petitioners made no effort to qualify or contradict these or a dozen similar statements.

Petitioners' own economists proved the point. Their principal expert testified flatly that the relevant market in which Compcare competes is "health care financing." Tr. 788. Their damages expert testified that switching between HMO and indemnity products "happens periodically throughout the health care financing market." Tr. 2612. Neither one asserted a separate "HMO services" market. Respondents' economist made it unanimous, testifying that there was no relevant "HMO" market, but only a "health care financing" market. Tr. 2059-64.

Petitioners' own executives proved the point. A Blue Cross vice president testified that "Compcare competes with the parent company Blue Cross." Tr. 81. A Blue Cross sales director testified that Security is a "major competitor" of Blue Cross. Tr. 680. Several large employers also acknowledged interchangeability among HMOs and other forms of health care financing. Tr. 2061-62. Indeed, as petitioners' own evidence showed, the City of Marshfield itself switched from Security's HMO product to Blue Cross's indemnity product. Tr. Ex. 1991.

Petitioners offered no evidence indicating that consumers do *not* regard HMOs and other health plans as interchangeable. After petitioner's economist conceded that Compcare competes in the "health care financing" market, petitioners offered the "expert" opinion of Jeffrey Nohl, Compcare's own President. Mr. Nohl acknowledged that patients switch between HMO and indemnity products (Tr. 1144-45), but nonetheless opined that "HMO products" constitute a separate product market because of their "distinct characteristics" from indemnity products (Pet. App. 24a). Under that reasoning, Mr. Nohl agreed that there would exist a separate product market for "Buicks." Tr. 1147. That is not the law. While "distinct characteristics" have evidentiary significance in determining substitutability, *see Brown Shoe*, 370 U.S. at 325-26;

Rothery, 792 F.2d at 218, they cannot establish a separate product market where, as here, reasonable substitutability and substantial competition are undisputed. *See, e.g., United States v. Continental Can Co.*, 378 U.S. 441, 449 (1964) (metal and glass containers occupy single product market because of "admitted competition"); *du Pont*, 351 U.S. at 399 (no separate product market for cellophane because, despite "advantages," it "has to meet competition from other materials"); *Packard Motor Car Co. v. Webster Motor Car Co.*, 243 F.2d 418, 420 (D.C. Cir.) (no separate product market for Packards), *cert. denied*, 355 U.S. 822 (1957). On the controlling issue —substitutability—the record below fully supports the court of appeals' decision.[14]

B. The Affiliated Provider Contracts Contain No MFN Clause

Petitioners' second question presented, although convoluted, focuses primarily on an alleged MFN clause in the Security provider contracts. Pet. i (contracts "required" affiliates "to reduce their lucrative compensation from the dominant HMO if they accepted lower offers from another HMO"); Pet. 19-20 (discussing "MFN clauses"). Nowhere in the proceedings below, however, did petitioners suggest that the provider contracts even contain an MFN clause, much less one that unreasonably

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[14] Nor do petitioners make any pretense of having addressed the issue of supply substitution—that is, the ability of other physician groups or network-based health plans to convert to HMOs if it were profitable to do so. This is especially critical on a record such as this, where petitioners themselves operated PPOs and point-of-service plans in the same geographic area alleged to be monopolized by Marshfield's HMO. Pet. App. 6a. In this Court, petitioners now speculate on differences between PPOs and HMOs that might inhibit supply substitution. Pet. 17 n.15. They conveniently ignore the POS plan network, which is indistinguishable from an HMO network. Tr. 332, 344, 1125. But it was petitioners' burden to prove the relevant market at trial and to cite record evidence in the court of appeals. Speculation outside the record on a petition for certiorari will not do.

restrains trade. Indeed, the *only* mention of MFNs in the record below (Tr. 2926-27) involved Blue Cross's attempt to secure *for itself* an MFN clause by injunction. The MFN issue simply never arose until the court of appeals, charitably construing petitioners' argument about *per se* price fixing, created for petitioners an alternative argument that, in fact, petitioners themselves had never made. Pet. App. 16a-17a.

Emboldened by that assistance, petitioners now contend that the affiliated provider contracts state that affiliates "will be compensated for services provided for Security subscribers *at their usual fee rates*—so long as the affiliated physicians further agree to a 'most favored nation' ('MFN') clause *preventing* them from receiving *less* from any other patient or health plan." Pet. 4 (second emphasis added). In fact, however, the contracts say something very different:

> *Professional Fee.* Subject to the limitations outlined below, Clinic agrees to reimburse the Affiliated Provider(s) at a rate of eighty-five (85%) of the lesser of Provider's usual and customary charges and Plan's maximum allowable charge for covered care that is rendered to eligible Participants in Plan except as outlined below in Plan's Prepaid Medicare Program. This section is effective on October 1, 1989, the beginning of Plan's current fiscal year.

Opp. App. 1a (Tr. Ex. 1444).[15] This is the very language cited by petitioners to the court of appeals when it argued that the "practical result" of the agreements created a price "floor." Appellees' Br. at 15. As this language shows, these contracts do not reimburse affiliates at 100% of their "unusal" fee rates, as petitioners now contend, but at 85% of that rate—a 15% discount. More importantly, the contracts do not prevent affiliates

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[15] "Opp. App." refers to the appendix to this brief in opposition.

from charging *less* to other purchasers, either explicitly or in practical effect, since affiliates' compensation from Security is a function not of the *lowest* rate charged to any other purchasers, as an actual MFN clause would provide, but of the *usual* rate charged to most other purchasers. Moreover, anticompetitive impacts are particularly implausible here, where affiliates receive only a small portion of their income from Security. Pet. App. 3a. Finally, respondents presented uncontroverted testimony, from several affiliates themselves, that their contractual relationships with Security played "no role at all" (Tr. 1752) or "absolutely none whatsoever" (Tr. 1537) in determining the price to charge non-Security patients.[16]

Petitioners made no effort to show what the prices charged by the affiliates to other purchasers actually were. This failure is especially telling, because data showing the prices these affiliates charge to their Blue Cross-insured patients was plainly available to petitioners. Given these lapses in genuine proof, petitioners' extended frolic (Pet. 18-23) through "Post Chicago" literature in general, and MFN literature in particular, does not even begin to explain how the provider contracts at issue in this record could or did restrain trade unreasonably.

The record available in this case is desperately inadequate for the intelligent analysis of any issue of "HMO" market definition or MFNs. This Court would be ill-served to take a market definition case in which the most fundamental evidence of interchangeability is missing and the issue of supply substitution is ignored—in which the plaintiff's purported market definition is refuted by its own economist. This Court would be deeply frustrated to take

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[16] Petitioners also repeatedly make the unsupported assertion that the affiliated provider agreements are also "*de facto* exclusive contracts." *E.g.*, Pet. 9. To the contrary, the again-uncontroverted evidence showed that Security affiliates do contract with competing health plans, including Compcare and Valley Health Plan, another Blue Cross HMO. Tr. 1733-34, 1751-52, 1770-72.

a case to consider the actual operation and effect of "most favored nations" clauses in the healthcare industry, only to find that the contracts in question do not have them.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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